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Statement

Statement

of the

American Medical Association

Committee on Energy and Commerce
Subcommittee on Health
U.S. House of Representatives

RE: **Medicare Physician Payment: How to Build a Payment System that Provides Quality, Efficient Care for Medicare Beneficiaries**

July 25, 2006 and July 27, 2006

Division of Legislative Counsel
202 789-7426

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The American Medical Association (AMA) appreciates the opportunity to provide our views regarding "Medicare Physician Payment: How to Build a Payment System that Provides Quality, Efficient Care for Medicare Beneficiaries." We commend you, Mr. Chairman, and Members of the Subcommittee, for all your hard work and leadership in recognizing the fundamental need to address the fatally flawed Medicare physician payment update formula, called the sustainable growth rate, or SGR, and enhance quality of care for our nation's senior and disabled patients.

The AMA was founded in 1847 to advance quality of care and that goal remains paramount to the AMA and its physician members. Over the last 158 years, AMA efforts have strengthened medical licensure requirements, reformed medical training programs, and provided oversight for continuing medical education activities.

To further advance quality improvement, the AMA also convened the Physician Consortium for Performance Improvement (the Consortium) in 2000, well in advance of the current quality improvement environment that has since emerged across various sectors of the health care industry. The Consortium currently is working to meet its commitments to Congress and the Centers for Medicare and Medicaid Services (CMS) in furtherance of the development of physician performance measures, as discussed below. These efforts will assist Congress and CMS in advancing their goal of a physician payment system that delivers the highest quality of care to patients using health information technology (HIT) and quality improvement initiatives.

It is important to recognize, however, that the current Medicare physician payment update formula cannot coexist with a payment system that rewards improvement in quality. Quality improvements are aimed largely at eliminating gaps in care and are far more likely to increase rather than decrease utilization of physician services. In fact, data from the Medicare Payment Advisory Commission (MedPAC) suggest that some part of the recent growth in

Medicare spending on physicians' services is associated with improved quality of care. Under the SGR, however, physicians are penalized for this growth with annual cuts in Medicare payments. While Congress has intervened to avert these cuts in 2003 through 2006, it has done so by delaying cuts and pushing the problem into the future rather than adding more funds to the system. As a result, the gap between actual and allowed spending under the SGR has mushroomed to nearly $50 billion, half of which is attributable to the temporary "fixes" that were made in each of the last four years.

The Administration has often made the point that "it supports reforms in physician payment that provide better support for increasing quality and reducing overall health care costs, without adding to Medicare expenditures." It is difficult to see how structuring payments to reward quality could possibly eliminate the enormous SGR deficit that is triggering nine consecutive years of 5% physician pay cuts. Positive annual physician payment updates, that accurately reflect increases in physicians' practice costs, are vital for encouraging and supporting the significant financial investment required for HIT and participation in quality improvement programs. Currently, due to the SGR, the Medicare Trustees are forecasting payment cuts totaling 37% from 2007 through 2015.

We urge the Subcommittee to ensure that Congress acts this year before the October adjournment target date to: (i) avert the 5% cut for 2007 and enact a 2.8% physician payment update, as recommended by the Medicare Payment Advisory Commission (MedPAC); and (ii) repeal the SGR physician payment system and replace it with a system that adequately keeps pace with increases in medical practice costs. We emphasize to Congress that every time action to repeal the SGR is postponed, the cost of the next legislative fix, whether a short-term or long-term solution, becomes significantly higher and increases the risk of a complete meltdown in Medicare patients' access to care.

ADVANCES IN QUALITY IMPROVEMENT

In 2000, the AMA convened the Physician Consortium for Performance Improvement for the development of performance measurements and related quality activities. The Consortium brings together physician and quality experts from 70+ national medical specialty societies and almost 20 state medical societies, as well as representatives from the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality (AHRQ), and the Consumer-Purchaser Disclosure Project. The Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance (NCQA) are also liaison members.

The Consortium has become the leading physician-sponsored initiative in the country in developing physician-level performance measures. CMS is now using the measures developed by the Consortium in its large group practice demonstration project on pay-for-performance, and plans to use them in demonstration projects authorized by the MMA. Further, the Consortium has been working with Congress to improve quality measurement efforts, as well as with CMS to ensure that the measures and reporting mechanisms that could form the basis of a voluntary reporting program for physicians reflect the collaborative work already undertaken by the AMA, CMS, and the rest of the physician community. To achieve our mutual quality improvement goals, the AMA has taken the following steps:

- The AMA has allocated significant additional resources to accelerate the development of physician performance measures. We are in the process of doubling the staff dedicated to performance measure development, which is allowing us to significantly accelerate the work of the Consortium. By the end of 2006, the Consortium plans to have developed at least 140 physician performance measures.

- To date, the Consortium has developed 98 measures covering 17 clinical conditions, and an additional 52 measures have been drafted and are moving through the Consortium approval process. They are expected to be completed by the end of this year.

- Consortium measures developed to date account for conditions covering a substantial portion of Medicare spending. For example, according to the Congressional Budget Office, 85% of Medicare spending is "strongly linked" to high-cost beneficiaries with chronic conditions like coronary artery disease, chronic obstructive pulmonary disease, congestive heart failure and diabetes. Completed Consortium measures address these four conditions.

- The AMA's Current Procedural Terminology (CPT) Editorial Panel has also put in place an expedited process for developing and approving CPT II codes. Use of CPT II will allow physicians to submit quality data to CMS on the claim form for the particular service furnished to the patient, and many stakeholders believe this is a better alternative than the proposed G codes developed by CMS for reporting quality data. The AMA has developed and approved CPT II codes for all completed measures, and will continue to fast-track approval of these codes as additional measures are developed.

- The AMA/Consortium is continuing to accelerate the development of measures and is working through the National Quality Forum (NQF) for endorsement and Ambulatory Care Quality Alliance (AQA) for implementation to ensure that a uniform set of measures is used by all parties.

- The AMA is continuing to expand educational activities for our member physicians on incorporating quality measurement and improvement in their practices.

As the AMA continues in our ongoing efforts to enhance quality improvement, we strongly urge federal policymakers to ensure the development of a quality reporting program that physicians are confident will improve quality of care. To maximize such physician confidence, certain principles are paramount. First, performance measures should be developed through a transparent and consistent process through the Consortium. They should then be reviewed and endorsed by the NQF and implemented in a uniform manner across all payers and other entities through the Ambulatory Care Quality Alliance AQA. The AMA believes it is critical for CMS to work through these existing multi-stakeholder groups to pursue its quality roadmap. CMS already participates in these groups as well. Without input

and buy-in from physicians, patients, private sector purchasers and health plans, establishing successful quality improvement initiatives will be extremely difficult.

Second, the selection of performance measures must be governed by certain tenets: (i) measures should be developed for areas of medical care where there is the greatest need for quality improvement; (ii) there should be evidence showing that a measure is meaningful, *i.e.*, that following the guidelines specified by the measure will actually improve quality of care; (iii) measures should be developed for medical conditions that have a high cost for the health care system; and (iv) measures should cut across as many specialties as possible, with uniformity across all specialties that treat that same medical condition.

In developing physician measures, it is critical to recognize the complexities involved in developing and selecting performance measures for the physician community, as compared to other types of health care providers, such as hospitals. It is extremely difficult to develop measures that apply to many or all physicians because there are so many different types of medical specialties that treat multiple medical conditions. Hospitals and other health care institutions, by comparison, are more homogenous and thus it is easier to develop measures that apply to most or all hospitals.

Third, the primary factor in creating physician confidence in a reporting program is a Medicare physician payment system that adequately reflects increases in medical practice costs, as well as one that offsets physicians' costs incurred in reporting quality data. As noted above, the SGR and a system that rewards quality improvement are incompatible. Quality improvements are expected to encourage more preventive care, better management of chronic conditions, lower rates of hospital-acquired infections and fewer complications of surgery. While such results would reduce spending for hospital services covered by Part A of Medicare, they do so by increasing spending for the Medicare Part B physicians' services that are included in the SGR, and thus cannot compensate for the $50 billion deficit that has already accumulated in the SGR.

The majority of performance measures, such as those focused on prevention and chronic disease management, ask physicians to deliver more care. This conclusion is consistent with a long-term national study (*The Rewarding Results Project*) by the Leapfrog Group, including seven experimental projects designed to test a variety of pay-for-performance models. The study showed significant increases in physician visits for many services. MedPAC also evaluated the impact on quality of care with regard to 38 quality measures for ambulatory care. Initial results show that the number of patients receiving appropriate care increased for 20 of the 38 measures and remained the same for most others. Significantly, the study also found that for several measures, increases in the use of physician services was associated with declines in potentially avoidable hospitalizations.

More physician services means increased Medicare spending on physician services. The SGR imposes an arbitrary target on Medicare physician spending and results in physician pay cuts when physician spending exceeds the target. Thus, more physician services under a quality reporting program will result in more physician pay cuts.

Further, pay-for-performance programs depend on greater physician adoption of information technology, which was indicated by the Leapfrog study, at great cost to physician practices. A study by Robert H. Miller and others found that initial electronic health record costs were approximately $44,000 per full-time equivalent (FTE) provider per year, and ongoing costs were about $8,500 per FTE provider per year. (*Health Affairs*, September/October, 2005). Initial costs for 12 of the 14 solo or small practices surveyed ranged from $37,056 to $63,600 per FTE provider. Unless physicians receive positive payment updates, these HIT investments will not be possible. In fact, a 2006 AMA survey shows that if the projected nine years of cuts take effect, 73% of responding physicians will defer purchase of new medical equipment, and 65% will defer purchase of new information technology. Even with just one year of cuts, half of the physicians surveyed will defer purchases of information technology.

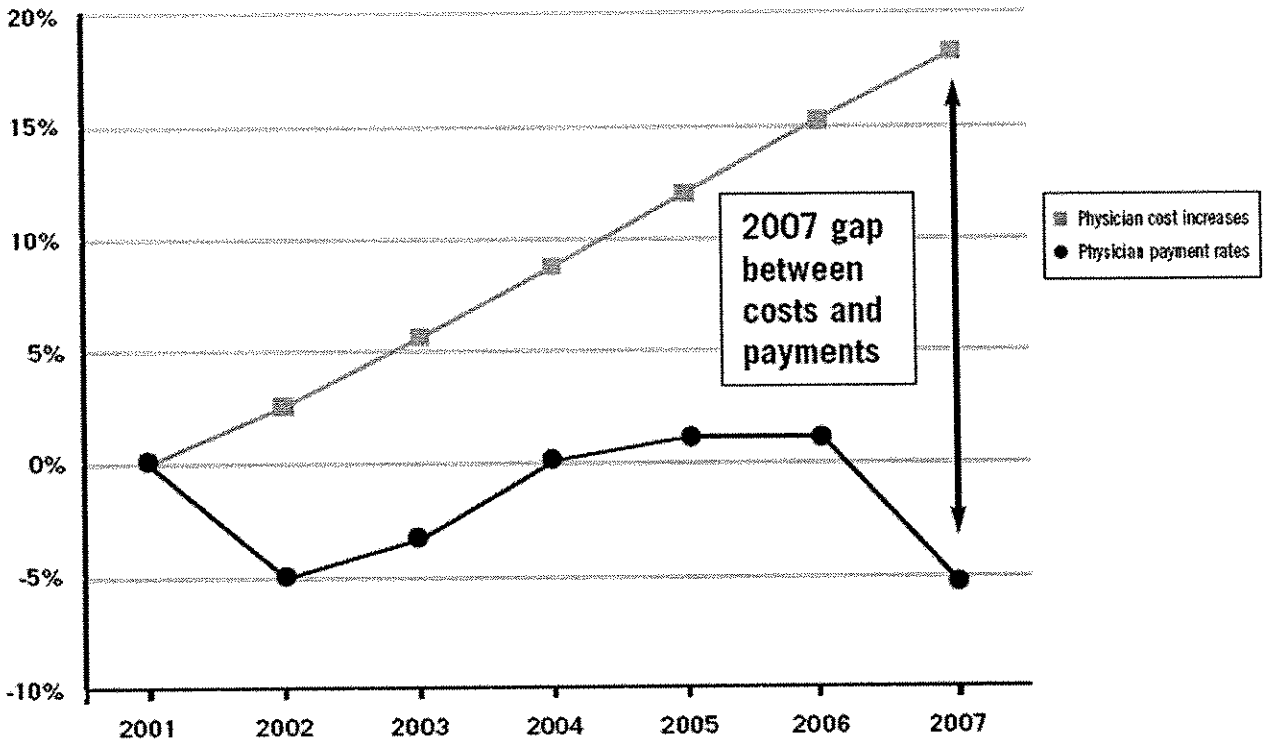
Because of the potentially significant administrative costs to physicians in reporting the quality data, we urge the Subcommittee to ensure that any quality reporting program are premised on: (i) positive Medicare payment updates that reflect increases in physicians' practice costs; and (ii) additional payments to physicians for reporting quality data.

The AMA looks forward to continuing our work on quality improvement with Congress and CMS. Working together, the Administration, Congress, and the physician community can strengthen the Medicare program by maximizing quality of care, as well as establishing a stable physician payment system, with adequate, positive updates that preserve Medicare patient access to their physician of choice.

CONGRESSIONAL ACTION IS NEEDED THIS YEAR TO HALT PHYSICIAN PAYMENT CUTS

The AMA is grateful to the Subcommittee and Congress for taking action to forestall steep Medicare physician payment cuts in each of the last four years. Yet, a crisis still looms, and, in fact, is getting worse. **Congress must act this year, before the October target adjournment date, to avert the almost 5% physician pay cut that is projected for January 1, 2007, along with a total of 37% in cuts from 2007 through 2015.**

These cuts will occur as medical practice costs, even by the government's own conservative estimate, are expected to rise by 22%. They follow five years of payment updates that have not kept up with practice cost increases. As the chart below illustrates, payment rates in 2006 are about the same as they were in 2001. In fact, data in a recent proposed rule impacting physician payments indicate that Medicare now covers only two-thirds of the labor, supply and equipment costs that go into each service.



There is widespread consensus that the SGR formula needs to be replaced: (i) there is bipartisan recognition in this Subcommittee and Congress that the SGR, with its projected physician pay cuts, must be replaced with a formula that reflects increases in practice costs; (ii) MedPAC has recommended that the SGR be replaced with a system that reflects increases in practice costs, as well as a 2.8% payment update for 2007; (iii) CMS Administrator McClellan has stated that the current physician payment system is "not sustainable;" and (iv) the Military Officers Association of America (MOAA) has stated that payment cuts under the SGR would significantly damage military beneficiaries' access to care under TRICARE, which will have long-term retention and readiness consequences.

Only physicians and other health professionals face such steep cuts. Other providers have been receiving updates that fully keep pace with their costs (and will continue to do so under current law). In 2006, for example, updates for other providers were as follows: 3.7% for hospitals, 3.1% for nursing homes, and 4.8% for Medicare Advantage (MA) plans (which are already paid at an average of 111% of fee-for-service costs). In addition, CMS announced earlier this year a 7.1% update for MA plans for 2007, which is used to develop a benchmark against which MA plans submit bids (for providing Part A and B benefits to enrollees). Using this as a benchmark, CMS expects an average MA update of 4% in 2007, with some plans still receiving up to 7.1%.

Physicians and other health care professionals (whose payment rates are tied to the physician fee schedule) must have payment equity with these other providers. Physicians are the foundation for our nation's health care system, and thus a stable payment environment for their services is critical.

THE MEDICARE SUSTAINABLE GROWTH RATE FORMULA

Fundamental Flaws with the SGR

The projected physician pay cuts are due to the SGR formula, which has two fundamental problems:

1. Payment updates under the SGR formula are tied to the growth in the gross domestic product, which does not factor in patient health care needs, technological advances or physician practice costs; and

2. Physicians are penalized with pay cuts when Medicare spending on physicians' services exceeds the SGR spending target, yet, the SGR is not adjusted to take into account many factors beyond physicians' control, including government policies and other factors, that although beneficial for patients, increase Medicare spending on physicians' services.

Because of these fundamental defects, the SGR led to a 5.4% cut in 2002, and additional reductions in 2003 through 2006 were averted only after Congress intervened and replaced projected steep negative updates with positive updates of 1.6% in 2003, 1.5% in each of 2004 and 2005, and a freeze in 2006. We appreciate these short-term reprieves, yet, even with this intervention, the average Medicare physician payment updates during these years were less than half of the rate of inflation of medical practice costs.

Now physicians are facing nine additional years of cuts. The vast majority of physician practices are small businesses, and the steep losses that are yielded by what is ironically called the "sustainable growth rate," would be unsustainable for any business, especially small businesses such as physician office practices.

Increases in Volume of Services

Some have argued that the SGR formula is needed to restrain the growth of Medicare physicians' services. The AMA disagrees.

Spending targets, such as the SGR, cannot achieve their goal of restraining volume growth by discouraging inappropriate care. Spending target systems are based on the fallacious premise that physicians alone can control the utilization of health care services, while ignoring patient demand, government policies, technological advances, epidemics, disasters and the many other contributors to volume growth. In addition, expenditure targets do not provide an incentive at an individual physician level to control spending, nor do they distinguish between appropriate and inappropriate growth. At a recent hearing before this Subcommittee concerning Medicare imaging cuts, CMS officials argued that recent rapid increases in the use

of imaging service raises questions about whether such growth is appropriate, but CMS did not provide the Subcommittee with any evidence of inappropriate growth.

Further, volume growth has continued at a relatively constant rate despite the SGR, and any assumption that this growth is inappropriate ignores the fact that spending on physician services is growing for a number of legitimate reasons. The number of elderly Americans is increasing and more of them suffer from obesity, diabetes, kidney failure, heart disease, and other serious chronic conditions. In addition, last year, Medicare officials announced that spending on Part A services was decreasing. This suggests that, as technological innovations advance, services are shifting from Part A to Part B, leading to appropriate volume growth on the Part B side. In fact, new technology and drugs have made it possible to treat more people for more diseases and provide this treatment in physicians' offices rather than in more expensive hospital settings. Quality improvement initiatives in providing medical services have also reached out to more beneficiaries, which, in turn, has increased volume. This has led to fewer hospital admissions, shorter lengths of stay, longer life spans with better quality of life, and fewer restrictions in activities of daily living among the elderly and disabled. One of the more interesting findings in MedPAC's 2006 Report to Congress is that, based on its 38 quality tracking measures, more Medicare beneficiaries received necessary services in 2004 than in 2002 and potentially avoidable hospitalizations declined as well.

The foregoing suggests that a number of factors drive appropriate volume growth and that spending on physicians' services is a good investment. In fact, the government recently reported that U.S. life expectancy reached a record high of 77.9 years. In addition, the National Center for Health Statistics reported that there were 50,000 fewer U.S. deaths in 2004, the biggest single-year drop in mortality since the 1930s. Despite the aging of the population and growing rates of obesity, reductions in deaths due to heart disease, cancer and stroke accounted for most of the improvement.

We urge Congress, in developing a new physician payment system, to ensure that the first priority is to meet the health care needs of our elderly and disabled patients, as well as avoid a system that forestalls the major improvements in medical care and quality of care described above. To achieve this goal, Congress and policymakers should not impose spending targets that effectively penalize all physicians for volume growth — whether appropriate or inappropriate. **Rather, if there is a problem with inappropriate volume growth regarding a particular type of medical service, Congress and CMS should address it through targeted actions that deal with the source of the increase. This would give Congress more control over the process than exists under the current system.**

COMPOUNDING FACTORS TO THE SGR IN 2007

In addition to the 2007 physician cuts, due to the flawed SGR, other Medicare physician payment policy changes will take effect on January 1, 2007, and will have a significant impact on a large number of physicians. These include: (i) expiration of the MMA provision that increased payments in 58 of the 89 Medicare payment localities; and (ii) recent CMS proposals that will change both the "work" and "practice expense" relative values, each of which are components in calculating Medicare physician payments for each individual medical service. These changes, many of which were supported by the AMA, will mitigate the impact of the SGR cuts for some specialties. However, a required budget neutrality

adjustment could lead to cuts of 5% or more for other physicians' services, and we are concerned that the combined impact of the SGR cut with these budget neutrality adjustments could jeopardize the financial viability of some practices.

The AMA is also concerned about cuts in imaging services furnished in physicians' offices, as mandated by the DRA, which are scheduled to be implemented beginning January 1, 2007. These imaging cuts will exacerbate the looming Medicare payment crisis, and the AMA requests that these cuts be repealed or delayed in accordance with AMA policy adopted by our House of Delegates in June 2006.

The Medicare physician payment system has a multitude of moving parts. We urge the Subcommittee to recognize that, for many physicians, these foregoing factors will compound the 2007 physician pay cuts due to the SGR and, taken together, these cuts will substantially deter the existing momentum in the physician community to move in the direction of adopting HIT and making the financial investment necessary to participate in quality improvement programs. Congress must provide physicians' with an adequate payment system that supports Congress' goal of an HIT- and quality improvement-based system.

It is also important to recognize that despite all the different factors that will affect Medicare physician payment rates in 2007, physicians are united in their view that the most important problem that Congress needs to address is the 5% pay cut scheduled to take effect January 1, 2007. This cut will reduce payments for all specialties and all payment localities, and action by Congress to replace this 5% cut with a positive 2.8% update for 2007 will help physicians in every state and specialty.

ACCESS PROBLEMS FOR MEDICARE BENEFICIARIES UNDER THE CURRENT MEDICARE SGR PHYSICIAN PAYMENT FORMULA

AMA Survey Shows Patient Access Will Significantly Decline if the Projected SGR Cuts Take Effect

Physicians simply cannot absorb the pending draconian payment cuts, and an inadequately funded payment system will be most detrimental to Medicare patients. Although physicians want to treat seniors, Medicare cuts are forcing physicians to make difficult practice decisions. According to a 2006 AMA survey:

- Nearly half (45%) of the responding physicians said that if the scheduled cut in 2007 is enacted, they will be forced to either decrease or stop seeing new Medicare patients, and 43% responded the same with respect to TRICARE patients.

- By the time the full force of the cuts takes effect in 2015, 67% of physicians will be forced to decrease or stop taking new Medicare patients. The same percentage of physicians responded in the same way with respect to TRICARE patients.

- If the cut in 2007 goes into effect, 71% of responding physicians said they will make one or more significant patient care changes, including reducing time spent with Medicare patients, increasing referral of complex cases and ceasing to provide certain services.

- Almost two-thirds of responding physicians said that in their community: (i) more Medicare patients are being treated in the emergency room for conditions that could have been treated in a physician's office; (ii) more physicians are referring Medicare patients with complex problems to other physicians; and (iii) it has become more difficult to refer Medicare patients to certain medical and surgical specialists.

- In rural areas, more than 1/3 of physicians (37%) said they will be forced to cut off outreach services if the scheduled cut in 2007 is enacted, with more than half (55%) discontinuing rural outreach services if the cuts are enacted through 2015.

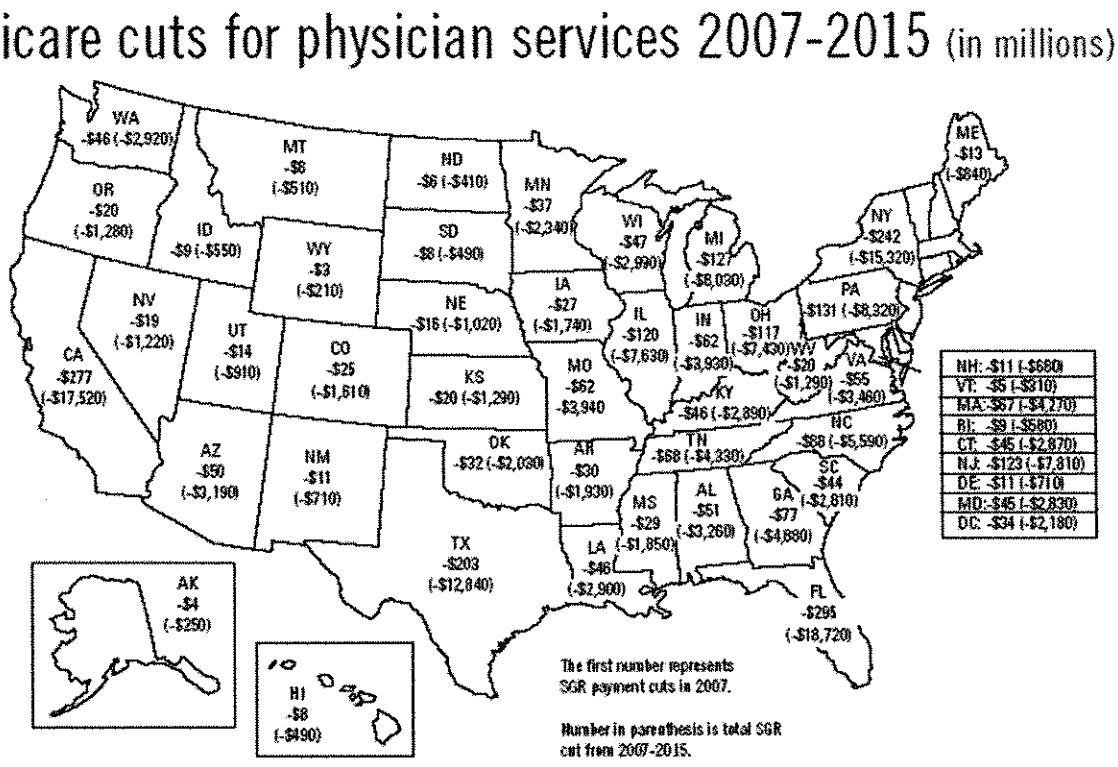
Continual physician pay cuts put patients' access to care at risk, and there are signs of a problem already. A MedPAC survey found that, in 2005, 25 percent of Medicare patients looking for a new primary care physician had some problem finding one and that a growing number had a "big problem." It concluded that some beneficiaries "may be experiencing more difficulty accessing primary care physicians in recent years and to a greater degree than privately insured individuals."

In the long-run, all patients may have more trouble finding a physician. The Congressionally-created Council on Graduate Medical Education is already predicting a shortage of 85,000 physicians by 2020, and multi-year cuts in Medicare are nearly certain to exacerbate this shortage by making medicine a less attractive career and encouraging retirements among the 35 percent of physicians who are 55 or older. These predictions of shortages are underscored by the demographics of practicing physicians in certain states. For example, nearly half of the practicing physicians in California and Florida and nearly 40% of practicing physicians in Georgia, Ohio and Texas are above the age of 50. A survey by a national physician placement firm found that just over half of physicians between the ages of 50 and 65 plan to take steps in the next one to three years that would either take them out of a patient care setting or reduce the number of patients they see.

Medicare physician cuts have a ripple effect across the entire health care system and drive down payment rates from other sources. For example, TRICARE, which provides health insurance for military families and retirees, ties its physician payment rates to Medicare, as do some state Medicaid programs. Thus, Medicare cuts trigger TRICARE and Medicaid cuts as well. In fact, MOAA has sent letters to Congress urging Congressional action to avert the physician payment rate cuts, which would "significantly damage" military beneficiaries' access to health care services. MOAA stated that "[w]ith our nation at war, Congress should make a particular effort not to reduce health care access for those who bear and have borne such disproportionate sacrifices in protecting our country."

Impact of Projected SGR Cuts on Individual States

If Congress allows the pay cuts forecast by the Medicare Trustees to go into effect, there will be serious consequences in each state across the country. As the map below illustrates, more than 35 states will see their health care funds reduced by more than one billion dollars by the time the cuts end in 2015. Florida and California are the biggest losers, with each of these states losing close to $300 million in 2007 alone. Medicare payments in Florida would be cut by more than $18 billion from 2007-2015; California will lose more than $17 billion over the 9-year period, and Texas is not far behind with nearly $13 billion in cuts. Ohio is facing losses of more than $7 billion and Georgia will see about $5 billion in cuts.



Sources: The projected Medicare SGR conversion factor cuts are from the 2006 Medicare Trustees Report, May 2006.
The source of the state-by-state analysis is the American Medical Association Division of Economic and Statistical Research, May 2006.

Seniors cannot afford to have their access to physicians jeopardized by further reducing Medicare payment rates below the increasing costs of running medical practices. Ohio's 1.6 million Medicare beneficiaries comprise 14% of the state's population and Florida's nearly 3 million beneficiaries are 16% of its population. Even before the forecast cuts go into effect, Georgia only has 208 practicing physicians per 100,000 population and Texas has 207 practicing physicians per 100,000 population, which means both states are far below the national average of 256. Florida only has 15 practicing physicians for every 1,000 Medicare beneficiaries, 25% below the national average.

The negative effects of the cuts in the Medicare physician payment schedule are not only felt by patients, but also by the millions of employees that are involved in delivering health care services in every community. Data from the Bureau of Labor Statistics show that the physician payment cuts will affect: 80,274 employees in Georgia; 112,176 employees in Ohio; 195,288 employees in Florida; 200,469 employees in Texas; and 292,171 employees in California.

We urge the Subcommittee to avoid the serious consequences for patients that will occur if the projected SGR cuts take effect, and establish a Medicare physician payment system that helps physicians serve patients by providing the positive payment updates and incentives needed to invest in HIT and quality improvement programs.

The AMA appreciates the opportunity to provide our views to the Subcommittee on these critical matters. We look forward to working with the Subcommittee and CMS to achieve a long-term, permanent solution to the chronic under-funding of physicians' services for our nation's senior and disabled patients and ensuring their access to the highest quality of care.